ARLINGTON CENTER FOR DERMATOLOGY
"Comprehensive Family Skin Care"
• Medical • Surgical • Cosmetic

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Prompt Pay/Self Pay Agreement

Patient Name _____

I understand that Arlington Center for Dermatology (ACD) is accepting me as a prompt pay (self-pay) patient as of the date of this signed document. This agreement is active from the date of this signed document.

All services provided to me at Arlington Center for Dermatology from this date forward, including Office Visits, Light Treatment, Blood draws and other procedures are my responsibility. I will be responsible for paying for any and all services I receive. The provider will not file a claim to Medicare, Medicaid, or any Insurance Company for services provided to me. Any amount paid by me will not be applied toward any insurance, Medicare, or Medicaid deductible.

Payment is due in full at the time of service. This means that at the time of service, I will be paying by cash, check, or credit card. I understand that some procedures may require a specimen be sent out for additional tissue processing and consultation, which could prompt an additional bill from ACD's preferred laboratories. ACD will notify me by the Patient Portal if this need arises.

I understand that if at any time I am (re)approved for Insurance coverage or Medicare and desire to file my charges to an active Insurance Company, I will notify Arlington Center for Dermatology and that it is my responsibility to do so. I will be considered a prompt pay patient until I notify Arlington Center for Dermatology in writing that I want my treatment charged to an insurance company.

I understand that it is ultimately my responsibility to inform Arlington Center for Dermatology of any change in my insurance eligibility status and my desire to submit services for payment to an insurance company.

I agree to the Prompt Pay/Self Pay Agreement as explained above:

Patient Signature: _____

Date Signed: _____